

SENATE SUBSTITUTE  
FOR  
SENATE COMMITTEE SUBSTITUTE  
FOR  
HOUSE BILL NO. 1446

AN ACT

To repeal sections 354.085, 354.405, 354.603 and 376.1350, RSMo, and to enact in lieu thereof ten new sections relating to health insurance, with an effective date for a certain section.

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BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI,  
AS FOLLOWS:

1           Section A. Sections 354.085, 354.405, 354.603 and 376.1350,  
2 RSMo, is repealed and ten new sections enacted in lieu thereof,  
3 to be known as sections 354.085, 354.405, 354.603, 376.429,  
4 376.430, 376.1253, 376.1350, 376.1393, 376.1450 and 376.1575, to  
5 read as follows:

6           354.085. No corporation subject to the provisions of  
7 sections 354.010 to 354.380 shall deliver or issue for delivery  
8 in this state a form of membership contract, or any endorsement  
9 or rider thereto, until a copy of the form shall have been  
10 approved by the director. The director shall not approve any  
11 policy forms which are not in compliance with the provisions of  
12 sections 354.010 to 354.380 of this state, or which contain any  
13 provision which is deceptive, ambiguous or misleading, or which  
14 do not contain such words, phraseology, conditions and provisions  
15 which are specific, certain and reasonably adequate to meet  
16 needed requirements for the protection of those insured. If a

1 policy form is disapproved, the reasons therefor shall be stated  
2 in writing; a hearing shall be granted upon such disapproval, if  
3 so requested; provided, however, that such hearing shall be held  
4 no sooner than fifteen days following the request. The failure  
5 of the director of insurance to take action approving or  
6 disapproving a submitted policy form within ~~[thirty]~~ forty-five  
7 days from the date of filing shall be deemed an approval thereof  
8 [until such time as the director of insurance shall notify the  
9 submitting company, in writing, of his disapproval]. The  
10 director may not disapprove any deemed policy form for a period  
11 of twelve months thereafter. If at any time during such twelve-  
12 month period the director determines that any provision of the  
13 deemed policy form is contrary to statute, the director shall  
14 notify the health services corporation of the specific provision  
15 that is contrary to statute, and the specific statute to which  
16 the provision is contrary to, and may request, if the director  
17 determines it to be necessary and appropriate, that the health  
18 services corporation file within thirty days of receipt of the  
19 request an amendment form that modifies the provision to conform  
20 to statute. Upon approval of the amendment form by the director,  
21 the health services corporation shall issue a copy of the  
22 amendment to each individual and entity to which the deemed  
23 policy form was previously issued and shall attach a copy of the  
24 amendment to the deemed policy form when it is subsequently  
25 issued. Such amendment shall have the force and effect as if the  
26 amendment was in the original filing or policy. If the deemed  
27 policy form is a certificate or other form issued to individual  
28 members, the health services corporation may fulfill its

1 obligation to issue the conforming amendment to members to whom  
2 the deemed policy form was previously issued by either:

3 (1) For group coverage, supplying the group contract holder  
4 with a sufficient number of copies of the amendment so that the  
5 group contract holder may distribute a copy to each member to  
6 whom the deemed policy form was previously issued; or

7 (2) For group or individual coverage, including a copy of  
8 the amendment or a description of its contents in the health  
9 services corporation's next scheduled mailing to members.

10 The director of insurance shall have authority to make such  
11 reasonable rules and regulations concerning the filing and  
12 submission of such policy forms as are necessary, proper or  
13 advisable.

14 354.405. 1. Notwithstanding any law of this state to the  
15 contrary, any person may apply to the director for a certificate  
16 of authority to establish and operate a health maintenance  
17 organization in compliance with this act. No person shall  
18 establish or operate a health maintenance organization in this  
19 state without obtaining a certificate of authority pursuant to  
20 sections 354.400 to 354.636. A foreign corporation may qualify  
21 pursuant to sections 354.400 to 354.636, subject to its  
22 registration to do business in this state as a foreign  
23 corporation pursuant to chapter 351, RSMo, and compliance with  
24 the provisions of sections 354.400 to 354.636.

25 2. Every health maintenance organization doing business in  
26 this state on September 28, 1983, shall submit an application for  
27 a certificate of authority pursuant to subsection 3 of this  
28 section within one hundred twenty days of September 28, 1983.

1 Each such applicant may continue to operate until the director  
2 acts upon the application. In the event that an application is  
3 not submitted or is denied pursuant to section 354.410, the  
4 applicant shall henceforth be treated as a health maintenance  
5 organization whose certificate of authority has been revoked.  
6 Any health maintenance organization licensed by the department of  
7 insurance prior to September 28, 1983, and complying with the  
8 paid-in capital or guarantee fund requirements of section 354.410  
9 shall be issued a certificate of authority upon filing an amended  
10 certificate of authority and an amended articles of incorporation  
11 that conform with sections 354.400 to 354.636. When the annual  
12 statement of a health maintenance organization subject to the  
13 provisions of sections 354.400 to 354.636 is filed and all fees  
14 due from the health maintenance organization are tendered, the  
15 health maintenance organization's certificate of authority to do  
16 business in this state shall automatically be extended pending  
17 formal renewal by the director, or until such time as the  
18 director should refuse to renew the certificate.

19 3. Each application for a certificate of authority shall be  
20 verified by an officer or authorized representative of the  
21 applicant, shall be in a form prescribed by the director, and  
22 shall set forth or be accompanied by the following:

23 (1) A copy of the organizational documents of the applicant  
24 such as the articles of incorporation, articles of association,  
25 partnership agreement, trust agreement, or other applicable  
26 documents, and all amendments thereto;

27 (2) A copy of the bylaws, rules and regulations, or similar  
28 document, if any, regulating the conduct of the internal affairs

1 of the applicant;

2 (3) A list of the names, addresses, and official positions  
3 of the persons who are to be responsible for the conduct of the  
4 affairs of the applicant, including all members of the board of  
5 directors, board of trustees, executive committee, or other  
6 governing board or committee, the principal officers if the  
7 applicant is a corporation, and the partners or members if the  
8 applicant is a partnership or association;

9 (4) A copy of any contract made or to be made between any  
10 providers and persons listed in subdivision (3) of this  
11 subsection and the applicant;

12 (5) A copy of the form of evidence of coverage to be issued  
13 to the enrollees;

14 (6) A copy of the form of the group contract, if any, which  
15 is to be issued to employers, unions, trustees, or other  
16 organizations;

17 (7) Financial statements showing the applicant's assets,  
18 liabilities, and sources of financial support. If the  
19 applicant's financial affairs are audited by independent  
20 certified public accountants, a copy of the applicant's most  
21 recent certified financial statement shall be deemed to satisfy  
22 this requirement unless the director directs that additional or  
23 more recent financial information is required for the proper  
24 administration of sections 354.400 to 354.636;

25 (8) A description of the proposed method of marketing the  
26 plan, a financial plan which includes a three-year projection of  
27 operating results anticipated, and a statement as to the sources  
28 of working capital as well as any other sources of funding;

1           (9) If the applicant is not domiciled in this state, a  
2 power of attorney duly executed by such applicant appointing the  
3 director, the director's successors in office, and duly  
4 authorized deputies, as the true and lawful attorney of such  
5 applicant in and for this state upon whom all lawful process in  
6 any legal action or proceeding against the health maintenance  
7 organization on a cause of action arising in this state may be  
8 served;

9           (10) A statement reasonably describing the geographic area  
10 or areas to be served;

11           (11) A description of the complaints procedures to be  
12 utilized as required by section 354.445;

13           (12) A description of the mechanism by which enrollees will  
14 be afforded an opportunity to participate in matters of policy  
15 and operation;

16           (13) Evidence demonstrating that the health maintenance  
17 organization has provided its enrollees with adequate access to  
18 health care providers; and

19           (14) Such other information as the director may require to  
20 make the determinations required in section 354.410.

21           4. Every health maintenance organization shall file with  
22 the director notice of its intention to modify any of the  
23 procedures or information described in and required to be filed  
24 by this section. Such changes shall be filed with the director  
25 prior to the actual modification. If a filing that is a document  
26 described in subdivision (4), (5), or (6) of subsection 3 of this  
27 section is disapproved, the reasons therefor shall be stated in  
28 writing and a hearing shall be granted upon such disapproval if

1 so requested; provided that such hearing shall be held no sooner  
2 than fifteen days following the request. If the director does  
3 not approve or disapprove the modification within [thirty] forty-  
4 five days of filing, such modification shall be deemed approved.  
5 If a filing that is deemed approved is a document described in  
6 subdivision (4), (5) or (6) of subsection 3 of this section, the  
7 director may not disapprove the deemed filing for a period of  
8 twelve months thereafter. If at any time during that twelve-  
9 month period the director determines that any provision of the  
10 deemed filing is contrary to statute, the director shall notify  
11 the health maintenance organization of the specific provision  
12 that is contrary to statute, and the specific statute to which  
13 the provision is contrary to, and may request, if the director  
14 determines it to be necessary and appropriate, that the health  
15 maintenance organization file within thirty days of receipt of  
16 the request an amendment form that modifies the provision to  
17 conform to the state statute. Upon approval of the amendment  
18 form by the director, the health maintenance organization shall  
19 issue a copy of the amendment to each individual and entity to  
20 which the deemed filing was previously issued and shall attach a  
21 copy of the amendment to the deemed filing when it is  
22 subsequently issued. Such amendment shall have the force and  
23 effect as if the amendment was in the original filing or policy.  
24 If the deemed policy form is an evidence of coverage or other  
25 form issued to individual enrollees, the health maintenance  
26 organization may fulfill its obligation to issue the conforming  
27 amendment to enrollees to whom the deemed policy form was  
28 previously issued by either:

1       (1) For group coverage, supplying the group contract holder  
2 with a sufficient number of copies of the amendment so that the  
3 group contract holder may distribute a copy to each enrollee to  
4 whom the deemed policy form was previously issued; or

5       (2) For group or individual coverage, including a copy of  
6 the amendment or a description of its contents in the health  
7 maintenance organization's next scheduled mailing to enrollees.

8       5. A health maintenance organization shall file all  
9 contracts of reinsurance. Any agreement between the organization  
10 and an insurer shall be subject to the laws of this state  
11 regarding reinsurance. All reinsurance agreements and any  
12 modifications thereto shall be filed and approved.

13       6. When the director deems it appropriate, the director may  
14 exempt any item from the filing requirements of this section.

15       354.603. 1. A health carrier shall maintain a network that  
16 is sufficient in number and types of providers to assure that all  
17 services to enrollees shall be accessible without unreasonable  
18 delay. In the case of emergency services, enrollees shall have  
19 access twenty-four hours per day, seven days per week. The  
20 health carrier's medical director shall be responsible for the  
21 sufficiency and supervision of the health carrier's network.  
22 Sufficiency shall be determined by the director in accordance  
23 with the requirements of this section and by reference to any  
24 reasonable criteria, including but not limited to,  
25 provider-enrollee ratios by specialty, primary care  
26 provider-enrollee ratios, geographic accessibility, reasonable  
27 distance accessibility criteria for pharmacy and other services,  
28 waiting times for appointments with participating providers,

1 hours of operation, and the volume of technological and specialty  
2 services available to serve the needs of enrollees requiring  
3 technologically advanced or specialty care.

4 (1) In any case where the health carrier has an  
5 insufficient number or type of participating providers to provide  
6 a covered benefit, the health carrier shall ensure that the  
7 enrollee obtains the covered benefit at no greater cost than if  
8 the benefit was obtained from a participating provider, or shall  
9 make other arrangements acceptable to the director.

10 (2) The health carrier shall establish and maintain  
11 adequate arrangements to ensure reasonable proximity of  
12 participating providers, including local pharmacists, to the  
13 business or personal residence of enrollees. In determining  
14 whether a health carrier has complied with this provision, the  
15 director shall give due consideration to the relative  
16 availability of health care providers in the service area under,  
17 especially rural areas, consideration.

18 (3) A health carrier shall monitor, on an ongoing basis,  
19 the ability, clinical capacity, and legal authority of its  
20 providers to furnish all contracted benefits to enrollees. The  
21 provisions of this subdivision shall not be construed to require  
22 any health care provider to submit copies of such health care  
23 provider's income tax returns to a health carrier. A health  
24 carrier may require a health care provider to obtain audited  
25 financial statements if such health care provider received ten  
26 percent or more of the total medical expenditures made by the  
27 health carrier.

28 (4) A health carrier shall make its entire network

1 available to all enrollees unless a contract holder has agreed in  
2 writing to a different or reduced network.

3 2. A health carrier shall file with the director, in a  
4 manner and form defined by rule of the department of insurance,  
5 an access plan meeting the requirements of sections 354.600 to  
6 354.636 for each of the managed care plans that the health  
7 carrier offers in this state. The health carrier may request the  
8 director to deem sections of the access plan as proprietary or  
9 competitive information that shall not be made public. For the  
10 purposes of this section, information is proprietary or  
11 competitive if revealing the information will cause the health  
12 carrier's competitors to obtain valuable business information.  
13 The health carrier shall provide such plans, absent any  
14 information deemed by the director to be proprietary, to any  
15 interested party upon request. The health carrier shall prepare  
16 an access plan prior to offering a new managed care plan, and  
17 shall update an existing access plan whenever it makes any change  
18 as defined by the director to an existing managed care plan. The  
19 director shall approve or disapprove the access plan, or any  
20 subsequent alterations to the access plan, within sixty days of  
21 filing. The access plan shall describe or contain at a minimum  
22 the following:

23 (1) The health carrier's network;

24 (2) The health carrier's procedures for making referrals  
25 within and outside its network;

26 (3) The health carrier's process for monitoring and  
27 assuring on an ongoing basis the sufficiency of the network to  
28 meet the health care needs of enrollees of the managed care plan;

1           (4) The health carrier's methods for assessing the health  
2 care needs of enrollees and their satisfaction with services;

3           (5) The health carrier's method of informing enrollees of  
4 the plan's services and features, including but not limited to,  
5 the plan's grievance procedures, its process for choosing and  
6 changing providers, and its procedures for providing and  
7 approving emergency and specialty care;

8           (6) The health carrier's system for ensuring the  
9 coordination and continuity of care for enrollees referred to  
10 specialty physicians, for enrollees using ancillary services,  
11 including social services and other community resources, and for  
12 ensuring appropriate discharge planning;

13           (7) The health carrier's process for enabling enrollees to  
14 change primary care professionals;

15           (8) The health carrier's proposed plan for providing  
16 continuity of care in the event of contract termination between  
17 the health carrier and any of its participating providers, in the  
18 event of a reduction in service area or in the event of the  
19 health carrier's insolvency or other inability to continue  
20 operations. The description shall explain how enrollees shall be  
21 notified of the contract termination, reduction in service area  
22 or the health carrier's insolvency or other modification or  
23 cessation of operations, and transferred to other health care  
24 professionals in a timely manner; and

25           (9) Any other information required by the director to  
26 determine compliance with the provisions of sections 354.600 to  
27 354.636.

28           3. In reviewing an access plan filed pursuant to subsection

1 2 of this section, the director shall deem a managed care plan's  
2 network to be adequate if, in lieu of the network information  
3 required by subdivision (1) of subsection 2 of this section, the  
4 health carrier submits a sworn affidavit signed by an officer of  
5 the health carrier stating that it meets one or more of the  
6 following criteria:

7 (1) The managed care plan is a Medicare + Choice  
8 coordinated care plan offered by the health carrier pursuant to a  
9 contract with the Federal Centers for Medicare and Medicaid  
10 Services;

11 (2) The managed care plan is being offered by a health  
12 carrier that has been accredited by the National Committee for  
13 Quality Assurance at a level of "accredited" or better, and such  
14 accreditation is in effect at the time the access plan is filed;

15 (3) The managed care plan's network has been accredited by  
16 the Joint Commission on the Accreditation of Health Organizations  
17 at a level of "accreditation without type I recommendations" or  
18 better, and such accreditation is in effect at the time the  
19 access plan is filed. If the accreditation applies to only a  
20 portion of the managed care plan's network, only the accredited  
21 portion will be deemed adequate; or

22 (4) The managed care plan network is accredited by any  
23 other accrediting organization that is approved by the Missouri  
24 department of insurance.

25 376.429. 1. All health benefit plans, as defined in  
26 section 376.1350, that are delivered, issued for delivery,  
27 continued or renewed on or after August 28, 2002, and providing  
28 coverage to any resident of this state shall provide coverage for

1 routine patient care costs as defined in subsection 6 of this  
2 section incurred as the result of phase III or IV of a clinical  
3 trial that is approved by an entity listed in subsection 4 of  
4 this section and is undertaken for the purposes of the  
5 prevention, early detection, or treatment of cancer.

6 2. In the case of treatment under a clinical trial, the  
7 treating facility and personnel must have the expertise and  
8 training to provide the treatment and treat a sufficient volume  
9 of patients. There must be equal to or superior,  
10 noninvestigational treatment alternatives and the available  
11 clinical or preclinical data must provide a reasonable  
12 expectation that the treatment will be superior to the  
13 noninvestigational alternatives.

14 3. Coverage required by this section shall include coverage  
15 for routine patient care costs incurred for drugs and devices  
16 that have been approved for sale by the Food and Drug  
17 Administration (FDA), regardless of whether approved by the FDA  
18 for use in treating the patient's particular condition, including  
19 coverage for reasonable and medically necessary services needed  
20 to administer the drug or use the device under evaluation in the  
21 clinical trial.

22 4. Subsections 1 and 2 of this section requiring coverage  
23 for routine patient care costs shall apply to clinical trials  
24 that are approved or funded by one of the following entities:

25 (1) One of the National Institutes of Health (NIH);

26 (2) An NIH Cooperative Group or Center as defined in  
27 subsection 7 of this section;

28 (3) The FDA in the form of an investigational new drug

1 application;

2 (4) The federal Departments of Veterans' Affairs or  
3 Defense;

4 (5) An institutional review board in this state that has an  
5 appropriate assurance approved by the Department of Health and  
6 Human Services assuring compliance with and implementation of  
7 regulations for the protection of human subjects (45 CFR 46); or

8 (6) A qualified research entity that meets the criteria for  
9 NIH Center support grant eligibility.

10 5. An entity seeking coverage for treatment, prevention, or  
11 early detection in a clinical trial approved by an institutional  
12 review board under subdivision (5) of subsection 4 of this  
13 section shall maintain and post electronically a list of the  
14 clinical trials meeting the requirements of subsections 2 and 3  
15 of this section. This list shall include: the phase for which  
16 the clinical trial is approved; the entity approving the trial;  
17 whether the trial is for the treatment of cancer or other serious  
18 or life threatening disease, and if not cancer, the particular  
19 disease; and the number of participants in the trial. If the  
20 electronic posting is not practical, the entity seeking coverage  
21 shall periodically provide payers and providers in the state with  
22 a written list of trials providing the information required in  
23 this section.

24 6. As used in this section, the following terms shall mean:

25 (1) "Cooperative group", a formal network of facilities  
26 that collaborate on research projects and have an established  
27 NIH-approved Peer Review Program operating within the group,  
28 including the NCI Clinical Cooperative Group and the NCI

1 Community Clinical Oncology Program;

2 (2) "Multiple project assurance contract", a contract  
3 between an institution and the federal Department of Health and  
4 Human Services (DHHS) that defines the relationship of the  
5 institution to the DHHS and sets out the responsibilities of the  
6 institution and the procedures that will be used by the  
7 institution to protect human subjects;

8 (3) "Routine patient care costs", shall include coverage  
9 for reasonable and medically necessary services needed to  
10 administer the drug or device under evaluation in the clinical  
11 trial. Routine patient care costs include all items and services  
12 that are otherwise generally available to a qualified individual  
13 that are provided in the clinical trial except:

14 (a) The investigational item or service itself;

15 (b) Items and services provided solely to satisfy data  
16 collection and analysis needs and that are not used in the direct  
17 clinical management of the patient; and

18 (c) Items and services customarily provided by the research  
19 sponsors free of charge for any enrollee in the trial.

20 7. For the purpose of this section, providers participating  
21 in clinical trials shall obtain a patient's informed consent for  
22 participation on the clinical trial in a manner that is  
23 consistent with current legal and ethical standards. Such  
24 documents shall be made available to the health insurer upon  
25 request.

26 8. The provisions of this section shall not apply to a  
27 policy, plan or contract paid under Title XVIII or Title XIX of  
28 the Social Security Act.

1       376.430. 1. Any health benefit plan, as defined in section  
2 376.1350, that provides coverage for prescription drugs or  
3 devices and that issues, uses or requires, a card or other  
4 technology for prescription claims submission and adjudication,  
5 and third-party administrators for self-insured plans, and state-  
6 administered plans, or the plan's agents or contractors that  
7 issue such cards or other technology, shall issue for the plan's  
8 insureds, enrollees, or participants, a uniform prescription drug  
9 information card or other technology that conforms to the  
10 standards and format of the current National Council for  
11 Prescription Drug Programs (NCPDP) Pharmacy ID Card  
12 Implementation Guide. Such cards or other technology shall  
13 include all of the NCPDP standard information required by the  
14 plan for submission and adjudication of claims for prescription  
15 drug or device benefits.

16       2. The provisions of this section shall become effective  
17 January 1, 2003, and shall apply to health benefit plans that are  
18 delivered or issued for delivery. The provisions of this section  
19 shall also apply to all health benefit plans which are renewed  
20 after the effective date of this section. For the purposes of  
21 this section renewal of a health benefit policy, contract, or  
22 plan is presumed to occur on each anniversary of the date on  
23 which coverage was first effective on the person or persons  
24 covered by the health benefit plan.

25       376.1253. 1. Each physician attending any patient with a  
26 newly diagnosed cancer shall provide the patient with a timely  
27 referral to an appropriate specialist within the provider network  
28 for a second opinion regarding the treatment of the patient's

1 type of cancer. If no specialist in that specific cancer  
2 diagnosis area is in the provider network, a referral shall be  
3 made to a nonnetwork specialist in accordance with this section.

4 2. Each health carrier or health benefit plan, as defined  
5 in section 376.1350, that offers or issues health benefit plans  
6 which are delivered, issued for delivery, continued or renewed in  
7 this state on or after January 1, 2003, shall provide coverage  
8 for a second opinion rendered by a specialist in that specific  
9 cancer diagnosis area when a patient with a newly diagnosed  
10 cancer is referred to such specialist by his or her attending  
11 physician. Such coverage shall be subject to the same deductible  
12 and coinsurance conditions applied to other specialist referrals  
13 and all other terms and conditions applicable to other benefits,  
14 including the prior authorization and/or referral authorization  
15 requirements as specified in the applicable health insurance  
16 policy.

17 3. The provisions of this section shall not apply to a  
18 supplemental insurance policy, including a life care contract,  
19 accident-only policy, specified disease policy, hospital policy  
20 providing a fixed daily benefit only, Medicare supplement policy,  
21 long-term care policy, short-term major medical policies of six  
22 months or less duration, or any other supplemental policy as  
23 determined by the director of the department of insurance.

24 376.1350. For purposes of sections 376.1350 to [376.1390]  
25 376.1393, the following terms mean:

26 (1) "Adverse determination", a determination by a health  
27 carrier or its designee utilization review organization that an  
28 admission, availability of care, continued stay or other health

1 care service has been reviewed and, based upon the information  
2 provided, does not meet the health carrier's requirements for  
3 medical necessity, appropriateness, health care setting, level of  
4 care or effectiveness, and the payment for the requested service  
5 is therefore denied, reduced or terminated;

6 (2) "Ambulatory review", utilization review of health care  
7 services performed or provided in an outpatient setting;

8 (3) "Case management", a coordinated set of activities  
9 conducted for individual patient management of serious,  
10 complicated, protracted or other health conditions;

11 (4) "Certification", a determination by a health carrier or  
12 its designee utilization review organization that an admission,  
13 availability of care, continued stay or other health care service  
14 has been reviewed and, based on the information provided,  
15 satisfies the health carrier's requirements for medical  
16 necessity, appropriateness, health care setting, level of care  
17 and effectiveness;

18 (5) "Clinical peer", a physician or other health care  
19 professional who holds a nonrestricted license in a state of the  
20 United States and in the same or similar specialty as typically  
21 manages the medical condition, procedure or treatment under  
22 review;

23 (6) "Clinical review criteria", the written screening  
24 procedures, decision abstracts, clinical protocols and practice  
25 guidelines used by the health carrier to determine the necessity  
26 and appropriateness of health care services;

27 (7) "Concurrent review", utilization review conducted  
28 during a patient's hospital stay or course of treatment;

1           (8) "Covered benefit" or "benefit", a health care service  
2 that an enrollee is entitled under the terms of a health benefit  
3 plan;

4           (9) "Director", the director of the department of  
5 insurance;

6           (10) "Discharge planning", the formal process for  
7 determining, prior to discharge from a facility, the coordination  
8 and management of the care that a patient receives following  
9 discharge from a facility;

10          (11) "Drug", any substance prescribed by a licensed health  
11 care provider acting within the scope of the provider's license  
12 and that is intended for use in the diagnosis, mitigation,  
13 treatment or prevention of disease. The term includes only those  
14 substances that are approved by the FDA for at least one  
15 indication;

16          (12) "Emergency medical condition", the sudden and, at the  
17 time, unexpected onset of a health condition that manifests  
18 itself by symptoms of sufficient severity that would lead a  
19 prudent lay person, possessing an average knowledge of medicine  
20 and health, to believe that immediate medical care is required,  
21 which may include, but shall not be limited to:

22           (a) Placing the person's health in significant jeopardy;

23           (b) Serious impairment to a bodily function;

24           (c) Serious dysfunction of any bodily organ or part;

25           (d) Inadequately controlled pain; or

26           (e) With respect to a pregnant woman who is having  
27 contractions:

28           a. That there is inadequate time to effect a safe transfer

1 to another hospital before delivery; or

2 b. That transfer to another hospital may pose a threat to  
3 the health or safety of the woman or unborn child;

4 (13) "Emergency service", a health care item or service  
5 furnished or required to evaluate and treat an emergency medical  
6 condition, which may include, but shall not be limited to, health  
7 care services that are provided in a licensed hospital's  
8 emergency facility by an appropriate provider;

9 (14) "Enrollee", a policyholder, subscriber, covered person  
10 or other individual participating in a health benefit plan;

11 (15) "FDA", the federal Food and Drug Administration;

12 (16) "Facility", an institution providing health care  
13 services or a health care setting, including but not limited to  
14 hospitals and other licensed inpatient centers, ambulatory  
15 surgical or treatment centers, skilled nursing centers,  
16 residential treatment centers, diagnostic, laboratory and imaging  
17 centers, and rehabilitation and other therapeutic health  
18 settings;

19 (17) "Grievance", a written complaint submitted by or on  
20 behalf of an enrollee regarding the:

21 (a) Availability, delivery or quality of health care  
22 services, including a complaint regarding an adverse  
23 determination made pursuant to utilization review;

24 (b) Claims payment, handling or reimbursement for health  
25 care services; or

26 (c) Matters pertaining to the contractual relationship  
27 between an enrollee and a health carrier;

28 (18) "Health benefit plan", a policy, contract, certificate

1 or agreement entered into, offered or issued by a health carrier  
2 to provide, deliver, arrange for, pay for, or reimburse any of  
3 the costs of health care services; except that, health benefit  
4 plan shall not include any coverage pursuant to liability  
5 insurance policy, workers' compensation insurance policy, or  
6 medical payments insurance issued as a supplement to a liability  
7 policy;

8 (19) "Health care professional", a physician or other  
9 health care practitioner licensed, accredited or certified by the  
10 state of Missouri to perform specified health services consistent  
11 with state law;

12 (20) "Health care provider" or "provider", a health care  
13 professional or a facility;

14 (21) "Health care service", a service for the diagnosis,  
15 prevention, treatment, cure or relief of a health condition,  
16 illness, injury or disease;

17 (22) "Health carrier", an entity subject to the insurance  
18 laws and regulations of this state that contracts or offers to  
19 contract to provide, deliver, arrange for, pay for or reimburse  
20 any of the costs of health care services, including a sickness  
21 and accident insurance company, a health maintenance  
22 organization, a nonprofit hospital and health service  
23 corporation, or any other entity providing a plan of health  
24 insurance, health benefits or health services; except that such  
25 plan shall not include any coverage pursuant to a liability  
26 insurance policy, workers' compensation insurance policy, or  
27 medical payments insurance issued as a supplement to a liability  
28 policy;

1           (23) "Health indemnity plan", a health benefit plan that is  
2 not a managed care plan;

3           (24) "Managed care plan", a health benefit plan that either  
4 requires an enrollee to use, or creates incentives, including  
5 financial incentives, for an enrollee to use, health care  
6 providers managed, owned, under contract with or employed by the  
7 health carrier;

8           (25) "Participating provider", a provider who, under a  
9 contract with the health carrier or with its contractor or  
10 subcontractor, has agreed to provide health care services to  
11 enrollees with an expectation of receiving payment, other than  
12 coinsurance, co-payments or deductibles, directly or indirectly  
13 from the health carrier;

14           (26) "Peer-reviewed medical literature", a published  
15 scientific study in a journal or other publication in which  
16 original manuscripts have been published only after having been  
17 critically reviewed for scientific accuracy, validity and  
18 reliability by unbiased independent experts, and that has been  
19 determined by the International Committee of Medical Journal  
20 Editors to have met the uniform requirements for manuscripts  
21 submitted to biomedical journals or is published in a journal  
22 specified by the United States Department of Health and Human  
23 Services pursuant to section 1861(t)(2)(B) of the Social Security  
24 Act, as amended, as acceptable peer-reviewed medical literature.  
25 Peer-reviewed medical literature shall not include publications  
26 or supplements to publications that are sponsored to a  
27 significant extent by a pharmaceutical manufacturing company or  
28 health carrier;

1           (27) "Person", an individual, a corporation, a partnership,  
2     an association, a joint venture, a joint stock company, a trust,  
3     an unincorporated organization, any similar entity or any  
4     combination of the foregoing;

5           (28) "Prospective review", utilization review conducted  
6     prior to an admission or a course of treatment;

7           (29) "Retrospective review", utilization review of medical  
8     necessity that is conducted after services have been provided to  
9     a patient, but does not include the review of a claim that is  
10    limited to an evaluation of reimbursement levels, veracity of  
11    documentation, accuracy of coding or adjudication for payment;

12          (30) "Second opinion", an opportunity or requirement to  
13    obtain a clinical evaluation by a provider other than the one  
14    originally making a recommendation for a proposed health service  
15    to assess the clinical necessity and appropriateness of the  
16    initial proposed health service;

17          (31) "Stabilize", with respect to an emergency medical  
18    condition, that no material deterioration of the condition is  
19    likely to result or occur before an individual may be  
20    transferred;

21          (32) "Standard reference compendia":

22           (a) The American Hospital Formulary Service-Drug  
23    Information; or

24           (b) The United States Pharmacopoeia-Drug Information;

25          (33) "Utilization review", a set of formal techniques  
26    designed to monitor the use of, or evaluate the clinical  
27    necessity, appropriateness, efficacy, or efficiency of, health  
28    care services, procedures, or settings. Techniques may include

1 ambulatory review, prospective review, second opinion,  
2 certification, concurrent review, case management, discharge  
3 planning or retrospective review. Utilization review shall not  
4 include elective requests for clarification of coverage;

5 (34) "Utilization review organization", a utilization  
6 review agent as defined in section 374.500, RSMo.

7 376.1393. A health carrier shall not be required to employ  
8 or contract with any provider who performs or induces abortions,  
9 or who provides any health care service which is contrary to the  
10 moral, ethical or religious beliefs or tenets of such health  
11 carrier. A provider shall not be required as a term or condition  
12 of employment or contractual relationship with a health carrier  
13 to perform or induce an abortion, or to provide any health care  
14 service that is contrary to the moral, ethical or religious  
15 beliefs or tenets of such provider. As used in this section, the  
16 term "abortion" shall mean as defined in section 188.015, RSMo.

17 376.1450. An enrollee, as defined in section 376.1350, may  
18 waive his or her right to receive documents and materials from a  
19 managed care entity in printed form so long as such documents and  
20 materials are readily accessible electronically through the  
21 entity's Internet site. An enrollee may revoke such waiver at any  
22 time by notifying the managed care entity by phone or in writing.  
23 Any enrollee who does not execute such a waiver and prospective  
24 enrollees shall have documents and materials from the managed  
25 care entity provided in printed form. For purposes of this  
26 section, "managed care entity" includes, but is not limited to, a  
27 health maintenance organization, preferred provider organization,  
28 point of service organization, and any other managed health care

1 delivery entity of any type or description.

2 376.1575. 1. There is hereby established the "Advisory  
3 Commission on Health Insurance Mandates" which shall advise and  
4 make recommendations to the general assembly regarding mandated  
5 health insurance benefits. The commission shall serve only in an  
6 advisory capacity to the general assembly and any recommendations  
7 made by such body shall not be binding upon the general assembly.  
8 The commission shall be composed of the following members:

9 (1) The chairperson of the house of representatives which  
10 would handle insurance issues;

11 (2) The chairperson of the committee of the senate which  
12 would handle insurance issues;

13 (3) One member who is an employer or an officer of an  
14 employer who employs more than one hundred employees, and who  
15 pays a portion of the employees' health insurance premiums, to be  
16 appointed by the governor with the advice and consent of the  
17 senate;

18 (4) One member who is an employer or an officer of an  
19 employer who employs fewer than one hundred employees, and who  
20 pays a portion of the employees' health insurance premiums, to be  
21 appointed by the governor with the advice and consent of the  
22 senate;

23 (5) Two individual purchasers of health insurance policies  
24 appointed by the governor with the advice and consent of the  
25 senate; and

26 (6) Two employees that pay a portion of their health  
27 insurance sponsored by their employers, appointed by the governor  
28 with the advice and consent of the senate.

1       2. The members of the commission shall elect a chairperson  
2 to serve a term of not longer than one year. Members appointed  
3 by the governor shall serve for four-year terms and until their  
4 successors are appointed. Provided, however, that the terms of  
5 half of the six original appointees shall be for two years. The  
6 members appointed by the governor shall be residents of Missouri.  
7 Any vacancy on the commission shall be filled in the same manner  
8 as the original appointment.

9       3. The commission shall conduct one or more meetings during  
10 each legislative session to receive inquiries, comments and  
11 suggestions from members of the general assembly, and shall  
12 conduct a mandated health benefit analysis and make one or more  
13 reports to the house of representatives and the senate  
14 concerning:

15       (1) The benefit and costs of each health insurance mandated  
16 benefit proposal and each offer of a health insurance benefit  
17 proposed during each session of the legislature;

18       (2) The benefits and cost of each health insurance mandated  
19 benefit and each offer of a mandated health insurance benefit  
20 currently a part of state law;

21       (3) Appropriate method or methods of determining the  
22 benefits and costs of possible future mandated health insurance  
23 benefits and mandated offers of health insurance benefits; and

24       (4) Such other matters as the commission may deem necessary  
25 or proper to analyze the benefits and costs of mandated health  
26 insurance benefits and mandated offers of health insurance  
27 benefits.

28       4. The members of the commission shall serve without

1 compensation in addition to their official compensation, but  
2 shall be reimbursed for actual and necessary expenses incurred in  
3 the performance of their official duties. Reimbursement for  
4 actual and necessary expenses incurred in the performance of the  
5 commission's official duties shall be provided by the director of  
6 the department of insurance from funds appropriated for such  
7 purpose. The department of insurance shall provide such support  
8 as the commission requires to aid it in the performance of its  
9 duties. Subject to appropriation, the commission may hire a  
10 health insurance actuary to assist the commission in its duties.

11 5. For purposes of this section, the term "mandated health  
12 insurance benefit" shall mean coverage or offering required by  
13 law to be provided by a health carrier to:

14 (1) Cover a specific health care service or services;

15 (2) Cover treatment of a specific condition or conditions;

16 or

17 (3) Contract, pay, or reimburse specific categories of  
18 health care providers for specific services; a mandated option is  
19 not a mandated health benefit.

20 6. The commission shall be established by October 1, 2002.